GUIDELINES FOR THE DISTRICT COLLECTOR

FOR EFFECTIVE IMPLEMENTATION OF FAMILY WELFARE PROGRAMME

GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
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Preface

Population as a problem has been engaging the attention of national leaders even before independence. As far back as in 1938, the National Planning Committee of the Indian National Congress under Jawaharlal Nehru observed that the size of the Indian population was a basic issue in National Economic Planning. In 1951, India became the first country in the world to have an officially sponsored and funded National Family Planning Programme. The programme has yielded results – it has reduced the birth rate from 41.7 in 1951-61 to 33.8 in 1984, but the demographic impact has been blunted on account of successes on the health front where the mortality rate has fallen from 22.8 in 1951-61 to 12.5 in 1984. The result of this paradox has been that the growth rate has been stagnating around 2.2 for the last decade.

We have set for ourselves the goal of NRR 1 by 2000 A.D. and population stabilisation by 2050. To achieve this, however, we would have to make a clear break from the present situation and with this in view a Revised National Family Planning Strategy has been prepared.

The new strategy carries the family welfare programme beyound the confines of the P.H.C. and health infrastructure and includes social engineering in fields such as status of women, raising age of marriage, literacy and education and socio-economic development including anti-poverty programmes. The success of such a programme would depend upon the close cooperation and concerted effort of all departments of Government – particularly Panchayat Raj, Education, Agriculture, Animal Husbandry, District Rural Development Agencies etc., who work in close contact with the rural population.

For the implementation of the strategy, the country will be viewed as consisting of 412 districts and about 9000 PHCs/medicare centres as catchment areas for which detailed plan of actions suited to local conditions will be drawn up.

The District is the administrative and development unit for effective management and coordination of the programme, and the Block and PHC the cutting edge for motivational work and delivery of services. Naturally the Collector/District Magistrate who is the overall

captain of the team which implements Government programme at the district level will have to play a nodal role in the family planning campaign. Through his leadership and managerial style, the Collector must enthuse and involve all the development departments in the district for promoting family welfare programme as a duty of national importance.

The present guidelines document provides a synoptic view of the important roles the District Collector must play as an innovative leaders, coordinator, facilitator and mobiliser of resources and also as communicator and motivator for effective implementation of family welfare programme. To facilitate the tasks, a few areas have also been identified and eloborated which require his attention for taking a coordinated and concentrated action. In addition, a few thrust areas have been identified for special efforts *viz.,* raising the age of marriage, child survival, immunisation etc. Other features suggested in this document are: background information for planning and organising sterilisation camps including laproscopic sterilisation.

A working group was formed at National Institute of Health and Family Welfare for the preparation of these guidelines under the Chairmanship of Professor Somnath Roy, Director of the Institute. This group worked for developing the guidelines and had also the benefit of field visits and direct interaction with District Collectors in some States. The efforts made by Professor Somnath Roy and his faculty in the Institute deserve appreciation for this applied work which has direct programme relevance for family welfare work at the district level. Special mention may also be made of senior administrators such as Miss Meera Seth, Additional Secretary and Comissioner (FW) and Shri S.K. Alok, Joint Secretary who were associated with finalisation of the guidelines for the District Collector.

I trust the guidelines will be found beneficial and will facilitate the efforts of the District Collectors in the effective promotion of family welfare programme.

S. Krishnakumar
Deputy Minister (Family Welfare)
Ministry of Health and Family Welfare
Government of India

Acknowledgement

The Director, National Institute of Health and Family Welfare (NIHFW) was entrusted by the Ministry of Health and Family Welfare with the responsibility of preparing guidelines for district collectors for effective implementation of family welfare programme.

The Director, NIHFW – Professor Somnath Roy formed a working group, consisting of members of the faculty, representing the discipline of health administration, demography, social sciences, communication etc., for this purpose. The group put in commendable efforts under the leadership of Prof. Somnath Roy. The members of the group are:

Dr. (Smt.) Rita Sapru
Dr. D.C. Dubey
Shri V.R. Naik
Dr. (Ms.) Amita Bardhan
Dr. (Smt.) Monica Sharma
Shri B.B.L. Sharma
Shri A.D. Tripathi

In the preparation of the guidelines, suggestions received from several senior officers in the Health Ministry and also from district chiefs of Gujarat and Madhya Pradesh, contacted during field visits, were very helpful. Special thanks are due to Miss Meera Seth, Additional Secretary and Commissioner (FW), Shri S.K. Alok, Joint Secretary, Shri A.K. Basu, Deputy Secretary and Dr. M.L. Roy, Deputy Commissioner in the Ministry of Health and Family Welfare for making valuable suggestions for improvement.

1. Introduction

Broad Demographic Features

The 1981 census recorded India's population as 685.2 millions. In 1951, it was around 362 millions with a birth rate of 39.9 and death rate of 27.4 per thousand population, growing at an annual rate of 1.26 per cent. Currently, it is estimated to be 740 millions, with a birth rate of 33 and death rate of 11 per thousand, yielding a natural growth rate of around 2.2 per cent per annum. The death rate has declined much faster than the birth rate, giving rise to the number of people surviving.

The Infant Mortality Rate (IMR), and indicator of the degree of fertility in the population and also a cause, continues to be very high. The all India average is estimated to be around 105 per thousand live births as compared with below 15 per thousand live births in some advanced countries.

Similarly, female literacy, which shows a strong association with reduction in family size, is only about 28 per cent for the country as a whole.

The mean age of marriage for females in the country is around 18 years. A sizeable proportion of marriages are still taking place amongst girls aged less than the minimum prescribed age of 18 years under the amended Child Marriage Restraint Act (1978).

Although the percentage of reproductive couples effectively protected by family planning methods showed a steadily rising trend during the 6th plan, the achievement of 32.2 per cent in March 1985 was far below the target of 37 per cent of that year. The achievement of target of 60 per cent couple protection by 2000 AD requires doubling of the achievement in the course of 14 years.

Why Fertility is High

The salient factors have been identified to be:

a. Caste, religion, language etc. continue to command people's allegiance to groups rather than the nation as a whole and promote parochial and competitive attitudes in which numerical strength of different groups are considered important.

b. Widespread poverty and continued preponderance of family

based economic activity resulting in persistence of social norms favouring large families.

c. Low status and subserviant role of women in family and society.

d. Inadequate attention to the social development in the planning process resulting in slow progress in the fields of education, health and social welfare, including the accessibility and availability of family planning methods.

e. Slow pace of socio-cultural change with continued widespread acceptance of traditional social norms *e.g.* age at marriage, preference for male children etc.

Consequences of Rapid Population Growth

The important ones are:

1. *Demographic consequences*

a. About 40 per cent (1981 census) of the population is below age 15 years. About 55 per cent of the total population (1981 census) is between 15-59 age group constituting the labour force. Almost half the population is economically dependent upon the other half, not fully or gainfully employed.

b. The deteriorating land-man ratio pushes out large number of rural migrants in search of jobs to a few large metropolitan cities thereby imposing a heavy burden on their civic facilities and distorting the pattern of urbanisation in the country as a whole.

2. *Economic consequences*

a. In developing countries a large and growing population aggravates their shortage of capital and prevents speedy build up of productive capabilities of human and material resources. This results in very slow improvement in the standard of living of the mass of the people.

b. Since large families are generally poor families, uncontrolled fertility accentuates the already existing wide disparities in wealth, income and opportunities.

3. *Health and nutrition*

Widespread malnutrition prevails especially in women and children of large-sized poor families, reduces vitality and energy for productive work amongst the women; impairs growth and development of the children; and predisposes to high levels of morbidity and mortality especially from communicable disease.

4. *Social*

Increased incidence of family disintegration, abandonment of children, exploitative child labour, rising trends in juvenile delinquency etc.

5. *Ecological consequences*

The uncontrolled growth of population in the long run causes pressure on land and other material resources such as water, air, forests, soil etc. which, if unchecked, can lead to natural calamities such as droughts, floods etc.

2. Review of Family Planning Programme

The Government of India was the first in the world to recognise officially that rise in the social, economic and health standards of Indian people are possible only when moderation in Indian fertility takes place and efforts are made in this direction.

Consequently, the national family planning programme was launched in the first five year plan with an outlay of Rs. 65 lakhs to promote biomedical and communication research and to set up family planning clinics. In recognition of close relationship between family planning and maternity and child health and welfare services this outlay was allocated to the health sector.

Thereafter, all the successive plans witnessed increased outlays on the family planning programme which reached the level of Rs. 1078 crores in the Sixth Five Year Plan.

Early Efforts

Starting with a few biomedical and communication research studies and the establishment of family planning clinics in hospitals and health centres the programme rapidly assumed the characteristics of a nationwide movement to induce millions of people to accept small family norm. It expanded to cover the entire country through an extension education approach alongwith static and mobile service facilities; the Hindustan Latex Corporation was established for the production of contraceptives; the Nirodh Marketing Programme was launched for countrywide commercial distribution of contraceptives through sales network existing in the private sector; the All India Hospital Post Partum Programme was started to maximise acceptance of family planning in maternity cases of hospitals and to strengthen the teaching of population dynamics, human reproduction, and contraception, in undergraduate medical education.

Simultaneously, a well defined organizational framework for the programme was initiated at central, state and district levels, including a widespread infrastructure for orientation training of programme personnel.

The programme was evaluated by Planning Commission as well

as U.N. evaluation teams by the end of third five year plan.

Strategic Measures

The management of the programme was characterised by several strategic measures such as the adoption of time bound target-oriented functioning for achieving specified demographic goals; cash incentives to acceptors and motivators; use of mass media and communication techniques and a camp and campaign approach for motivation and rendering of services to large numbers of people at a given place and time, large scale involvement of the organised and voluntary sectors and private practitioners.

Promotion of M.C.H.

Over the plan periods the family planning programme was directly responsible for the expansion of rural health infrastructure at primary health centre and subcentre levels. It also promoted maternal and child health through the provision of tetanus toxoid, and iron and folic acid to expectant mothers, and DTP immunisation, iron and folic acid, and Vitamin A to infant and pre-school children.

In order to increase knowledge on population issues and create favourable attitudes towards family planning in the coming generation, the subject of population education was initiated in schools and colleges.

3. Development of Population Policy

When the first five year plan started, the intention of Government was to stabilise the population growth at a level consistent with the national resources. It was considered possible to achieve this by reduction in birth rate. Fertility control therefore became the most important ingredient of population policy. Realising that this could be achieved only in an environment created by concomitant social, economic and political changes, the Government enunciated population policy statements in 1976 and 1977 both of which:

Salient Features

- raised the legal age of marriage for girls and boys to 18 and 21 years respectively;
- froze the representation of states in the Lok Sabha and Vidhan Sabhas on the basis of 1971 census until the year 2001;
- made the 1971 census population the basis for allocation of central assistance to state plans and devolution of duties and taxes and grants in aid to state governments. In addition — 8 percent of central assistance to state plans was specifically earmarked against performance in family planning;
- called for high priority to school education above middle level for girls and non-formal education for young women specially in states showing low levels of family planning;
- introduced group incentives for zila parishads, panchayat samities, teachers at various levels, co-operative societies, trade unions etc.
- the declaration of population policy of 1977 maintained that family welfare programme will be totally voluntary in nature for all time to come.

Special Emphasis for Coordinated Action

While this stand remains unchanged, the Government is committed to bring about a swift decline in birth rate with the strategy of giving family welfare programme the broadest possible social and economic dimensions.

This would call for coordinated action on the following major fronts:

1. *Status of women*

- female literacy and education
- participation in income generation activities
- enforcement of legal age at marriage
- promotion of community based associations of women *e.g.* cooperatives, mahila mandals etc.
- improved health protection of expectant and lactating mothers and at the time of delivery

2. *Child survival and development*

- increased availability of food
- promotion of breast feeding and improvement in weaning and feeding practices
- universal immunisation scherne
- monitoring of growth and development
- widespread propagation for oral rehydration treatment
- stricter regulation of child labour

3 *Poverty alleviation*

Effective implementation of schemes viz. NREP, IRDP, RLEG etc.

4. *Old age security*

Encouragement of schemes for old age pension, homes for aged, special health care, geriatric health care etc.

5. *Strengthening of health infrastructure*

Strengthening of health infrastructure and family welfare development system for increased coverage of remote rural areas and urban slums and better quality of service.

6. *Increased involvement of non-government agencies*

- voluntary organisations
- cooperatives
- private trusts and companies etc.

7. *Generating community participation by*

- formation of family welfare committees
- involvement of community groups such as youth clubs, mahila mandals and students associations etc.
- involvement of private medical practitioners, teaching community and elected representatives.

4. National Goals for Population Stabilisation in India

A stable population, is achieved when Net Reproduction Rate (NRR) equals 1. This is a replacement index implying that each woman leaving the reproductive age group (15-44 years) is replaced by the entry of only one woman. The overall goal is to achieve NRR 1 during the quinquennium 2006-2011 AD.

The subsidiary goals are as follows:

	Years	
	1990	2000
Birth rate	27.0	21.0
Death rate	10.4	9.0
Growth rate (Annual)	1.66	1.20
Effective couple protection (percentage)	42.0	60.0

In order to achieve the above goals approximately 66-67 million couples have to be motivated to accept family planning methods. The method-wise breakup of this acceptance has been targeted as follows by the end of the Seventh Five Year Plan:

Sterilisation	31 million
IUD	21.25 million
Conventional contraceptives	14.5 million

5. Organisation of Family Welfare Programme

Overall Goals, Strategy and Policies

i) Central Council of Health and Family Welfare chaired by Union Health Minister and comprising all State/UT Health Ministers, Health Secretaries, Health Directors, representatives of voluntary agencies and from the organised sectors.

ii) National Population Advisory Council chaired by Union Health Minister and comprising representatives of parliament, eminent professionals, voluntary agencies, programme planners, and managers and other concerned departments.

Administrative

i) *Central level:* The Union Minister of Health and Family Welfare is supported by Deputy Minister (FW). The Union Health Secretary is supported by Addl. Secretary-cum-Commissioners (FW) with a separate secretarial staff comprising Family Welfare Department, having administrative Joint Secretaries and Technical Programme Officers.

ii) *State level:* At the state level, the State Health Minister and Health Secretary are overall incharge. The programme is implemented by the Director Health Services through one of the senior most Additional Directors who is designated as State Family Welfare Officer. This officer is supported by the State Family Welfare Bureau, comprising units for Mass Media and Education, Demography and Evaluation, Field Evaluation and Administration, and the State Health Education Bureau.

iii) *District level:* The Chief Medical Officer/District Medical and Health Officer/District Health Officer of the district is overall incharge supported by a Deputy designated as District MCH & Family Welfare Officer. District Family Planning Bureau functions under this officer comprising units of Mass Media and Education, Health Education, Statistics, Field Evaluation and the District Public Health Nurse.

iv) *Block level:* In some states *e.g.* Jammu and Kashmir, a unit of health administration has been set up at block level with a Block Medical Officer incharge. In others the Medical Officer Incharge Primary Health Centre is the administrative functionary below the District level.

Service Delivery System/ Operational

i) *Rural*

a. *Village level:* A Health Guide at one per 1000 population is provided to motivate and inform people about availability of protective MCH care and FP services from trained health workers, distribution of contraceptives, oral rehydration salts etc.

Practising village midwives have been identified and trained for protective maternal and child health care, safe conduct of delivery, and family planning methods, and instructed to propagate these ideas and messages to the village community. Under the ICDS scheme, there is one anganwadi for every 1000 population staffed by a trained anganwadi worker to provide non-formal education to preschool children and supplementary feeding of expectant and lactating mothers and children below 6 years of age. The anganwadi workers function in close collaboration with health functionaries.

b. *Subcentre level:* One Male and one Female Health Worker are provided for every 5000 population for rendering primary health care MCH and FW services, including maintenance of records, referrals, training of village level functionaries, and immunisation. Specifically they distribute iron and folic acid tablets, Vitaim A, oral rehydration salt, Nirodh and oral pills, IUDs are inserted at this level and this is done in those States where Female Health Workers have been trained to do so, and the required equipments and supplies have been distributed to subcentre level.

c. *PHC level:* This level is staffed by 2-3 Medical Officers, an Extension Educator, and Male and Female Field Supervisors. The PHC handles referred MCH & FP cases from village subcentres and also organises its own clinics and domicilliary services to serve the local community. It offers full range of MCH & FW services.

However, sterilisation surgery, particularly of women, is confined to those PHCs which have adequate operation theatre facilities and trained medical officers. Generally, PHCs manage high risk MCH cases, provide delivery facilities, immunisation, nutritional rehabilitation of severely malnourished children, nutritional supplements, oral rehydration salts and treatment of severe diarrhoea, and distribution of nirodh, insertion of IUD, and vasectomy.

d. *District level:* Mobile van for conducting tubectomies, IUD insertions, vasectomy etc. are available and organised from district level by the District MCH & FW officers in collaboration with District Civil Hospitals and their Post Partum Units.

ii) *Urban*

a. *Urban family welfare centres (UFWCs):* One for 10,000/25,000/50,000 population, with prescribed staffing patterns has been set up in towns and cities for providing protective MCH care and FW services.

b. *Post partum units:* These have been established in hospitals down to sub-divisional level and provide operation theatre facilities, sterilisation beds, and medical and para-medical personnel for maximising acceptance of family welfare services, especially sterilisation surgery, in the maternity cases. Post Partum Units attached to teaching hospitals also provide staff for strengthening under-graduate medical education in demography, obstetrics and gynaecology, paediatrics and family welfare.

c. *Health posts:* These are being provided for urban slums and are staffed by female health workers at one for 5000 population and women volunteers at one for 2000 population to inform and motivate regarding the availability of, and render, primary health care, MCH and FW services.

d. *Under ICDS scheme:* Anganwadis with similar objectives and functions as in rural areas mentioned above have been made responsible for slum populations at the rate of one per thousand.

6. Assessment of MCH and Family Welfare Situation

1. This should include analysis of MCH and family welfare performance in the district over the past 5-10 years, according to primary health centres/talukas/towns/cities in the district. The district's average in terms of percentage achievement of target and couple protection rate need to be calculated and the comparison of performance between different service centres to be made with the district's average. Charts, graphs and diagrams may be prepared accordingly for display in the collectors' office, taluka, nagar and gram panchayats, municipalities and different rural and urban service centres.

2. The above analysis may also include compilation of daily cases of sterilisation over the past five years so that the high and low performing months in the district are known in advance and the plans are made accordingly.

3. Efforts should be made to ascertain resistant population groups, if any, and their locations, within the district so that the motivational efforts may be programmed accordingly.

4. Contacts to be established with all programme implementors down the village level to obtain relevant information particularly their perception of the programme, and how they consider it to be perceived by the community; staff morale, etc.

5. Indicators reflecting the district's demographic and socio-economic situation; mortality and morbidity in women and children; the availability and utilisation of family welfare and MCH services may be collected from appropriate sources and compiled for ready reference.

7. Roles of District Collector* in Family Welcome Programme

By virtue of the multidimensional nature of the population problem and the new broad based strategy for family welfare programme, the district collector being in overall command of all development programmes and schemes, becomes important at the district level. His effectiveness in energising all development functionaries to undertake family welfare duties and responsibilities, and his success in achieving wide public acceptance of family welfare would be largely determined by his style of functioning in the following roles.

Ensuring Policy Acceptance

Implementors should not be presumed to have deeply committed acceptance of family welfare policy as distinct from a formal acceptance as a result of official directives and circulars. Every effort should therefore be made to obtain this acceptance on ideological, intellectual and factual bases.

Leadership with Innovation

Being the representative of the government in the district, and in close touch with the people, he can utilise his knowledge, influence and authority to launch innovative strategies for the family welfare programme. This leadership should include coordination, innovation, facilitation, resource mobilisation and communication for the programme.

Ensuring Commitment

By personal example of hard work, courteous dealings, and human consideration, he can secure the willing submission of programme functionaries at all levels to the needs of the programme.

Motivation

The family welfare programme is essentially a corporate enterprise. Its human element at any level can never be taken for granted and constant feedback and sharing of information, participatory involvement, and consensus building needs to be ensured at all levels.

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* In States like Gujarat and Maharashtra where Panchayat Raj has taken root, the District Development Officer is incharge of all development programmes, including family welfare, with the District Collector playing a supportive role. The enlisted roles are therefore mainly applicable to the District Development Officer in these states.

Implementation and Planning

This would involve clarification and acceptance of the goals by all concerned and preparing a series of action plans for their achievement.

Programme Monitoring

This is to be done systematically through weekly review meetings at all levels and daily/weekly/monthly returns from the different service centres in order to minimise the interval between shortfalls in performance and remedial measures.

Instituting a System of Rewards and Recognition

In order to ensure sustained motivation of personnel at all levels it is necessary to institute a regular system of rewards and recognition. This is an area of innovation and several innovative methods have been adopted in different districts *e.g.* in Gujarat people who have done good work for family welfare are awarded certificates by notable personalities like District Collector, Chairman Zilla Parishad, Local MLA, etc. Arrangements are made to photograph the occasion and supply free photos to the recipients of the awards.

Problem Solving

Efforts should be made to know of the individual problems of programme personnel since high and continued levels of motivation and commitment of workers can only be obtained if efforts are made to remove their individual problems, frustrations and grievances.

Leadership in Family Welfare Programme

Leadership is a crucial factor in the implementation of the programme. It explains why the same programme goes differently, under two different persons all other factors remaining the same. The success of leadership must be based upon certain personal beliefs and convictions. Foremost amongst these is the national importance of the family planning programme. This enables the leader to establish the presence of the programme not only on paper but in the minds of implementors and the public in the remotest parts of the district. Family welfare also becomes a priority item in the work agenda of different agencies.

The second conviction is the central importance of the clients and their rights to freedom of choice, courtesy, dignity and self respect, and competent professional care rendered in a safe and convenient manner.

The third conviction is that in order that implementors accept the rights of clients they also have to be treated in the same manner. The leader therefore scrupulously avoids petty minded punitive action against low performers and always adopts a positive approach by recognising and rewarding the good performer.

1. *Forming/Activising of Popular Committees*

Full implementation of policies and programme strategies at the official level is possible through formation and active participation of interlinked popular committees at district/town/block/ and village levels. They should have members from all sections of the community *e.g.*

a. Elected representatives of people MP/MLA/MLC/Zila parishad
b. Members of Different political parties
c. Professional groups like lawyers, doctors, engineers, teachers
d. Members from cultural groups
e. Religious leaders
f. Media related people
g. Members of voluntary organisations in the area
h. Members from weaker section SC/STs
i. Artisan groups
j. Other important groups not specified

The District Collector may undertake measures to revamp and energise these committees by arranging for letters to be sent to their members by State leaders such as Chief Minister and Ministers of Health, Education Panchayats etc.

2. *Forming/Activising Official Interdepartmental MCH & FW Committees*

These committees, when regularly convened, would secure continuous involvement of various departments by identifying their specific roles and assigning to them specific tasks towards family welfare goals in the district. Health and family welfare officials in these committees would act as technical resource persons.

3. District level officers so far identified may be made responsible for coordinating MCH/family welfare activities in a taluka/tehsil/ assigned to them for this purpose.

4. Prestige camps may be organised in the name of individual officials and prominent personalities of the district in which they deploy their resources and machinery under the overall guidance of the District Collector. They will ensure their personal attendance at the camps, courteous dealings with acceptors, and strict adherence

to safety rules and procedures, since their future is at stake.

Intersectoral Coordination of Family Welfare Programme

Specific schemes of various other government departments and agencies can be drawn upon to supplement the efforts made under the family welfare and MCH programme directly or indirectly. Examples are given below:

Any government programme or scheme within the district, which has an educational, training, or manpower development component of any kind should also impart knowledge of the health aspects of maternal and child health and family welfare services and create favourable attitude towards their acceptance. The concerned officers in the district may be requested to contact District Chief Medical Officer and MCH & FW Officer for the necessary assistance.

Orientation to Local Mass Media Officials

Orientation of local mass media officials for mass communication of ideas of social and economic change which favour the acceptance of small family norm. For example importance of education and training of girls to earn a livelihood; delaying marriages of girls beyond the age of 20 years; attaching equal value to sons and daughters etc. Full use to also be made of all the mass media available in the district to publicise events and achievements of the MCH & FW programmes.

Organising of Special MCH & FW Referral Schemes

Special MCH & FW referral schemes may be organised with the help of district health authorities to serve the additional demand generated by non-health departments.

Motivation of Beneficiaries of Poverty Alleviation Schemes

Special emphasis may be laid on motivation of the beneficiaries of poverty alleviation schemes in the district to accept MCH & FW services. The list of these beneficiaries according to the areas of residence may be sent to medical officers incharge of all MCH & FW service giving facilities for taking necessary action through their field staff.

Use of Infrastructure of Rural Cooperatives

The infrastructure of buildings, transport, staff, marketing net works and funds etc. available with rural cooperatives *e.g.* Milk cooperatives, may be used to conduct specific maternal and child health and family welfare activities for the benefit of families of cooperative members *e.g.* distribution of iron and folic acid tablets, contraceptives, oral rehydration salts etc. An attempt may be made to form health cooperatives subsidiary to the main cooperative to achieve MCH & FW goals in the member families.

Close Monitoring of ICDS Blocks

Periodic and close monitoring to be done of ICDS blocks in the District particularly with regard to the following indicators:

- percentage of total villages/urban slums in the district covered with Anganwadis.
- percentage of eligible female population covered by functional literacy classes.
- percentage children 1-5 years enrolled in Anganwadis
- number and percentage expectant and lactating mothers and children 1-5 years receiving supplementary feeding at Anganwadis.

Creating Environment for Small Family Norm

All development projects and schemes which are meant to satisfy unmet basic human needs in different sections of the population of the district may be looked upon as vital means for creating an environment for the acceptance of small family norm and implemented speedily.

Examples of such schemes are:

- water supply and sanitation
- housing for economically weaker sections and rural landless labour
- non-formal elementary educational classes for girls
- expansion of primary schools
- local micro-level schemes of irrigation, agriculture and horticulture, animal husbandary and income generation schemes for women.

Intrasectoral Coordination for Family Welfare Programme

The health sector within a district comprises the following:

1. Health service network in rural and urban areas under the control of District Chief Medical Officer of health.
2. Government health service agencies coming under the control of railways, defence services, units of public sector undertakings etc.
3. Medical care organisations of the private corporate sector.
4. Voluntary agencies rendering maternal and child health and family planning services viz. district level branches of Family Planning Association of India, Red Cross Society of India, Missionery organisations, Gramin Mahila Sangh etc.
5. Associations of private medical practitioners and other kinds of health professionals of both the allopathic and indigenous systems of medicine.

6. Training and educational institutions for medical and paramedical and auxilliary health personnel in both allopathic and indigenous systems.

An outline of the total MCH/FW sector within the District, enlisting each and every kind of agency engaged in MCH/FP activities, may be prepared alongwith their facilities, resources, and range of services. Close working and collaborative relationship may be brought about under the captaincy of the District Collectors between all those agencies so that they mutually support each other by way of sharing of facilities and resources, training capabilities, transport, field staff, specialist expertise in communication, production of educational materials, sterilisation surgery etc. Government T.B. centres, Leprosy Control Centres in rural and urban areas alongwith all voluntary and private agencies engaged in T.B. and leprosy control activities, may be required to establish close to and fro linkages with MCH and FW service giving agencies. They may also undertake the rendering of specific MCH & FW services to the T.B. and leprosy cases.

Mobilisation of Resources for Family Welfare Programme

Urgent project proposals may be obtained from the District Chief Medical Officer of Health to fill in gaps in MCH/FW service giving capabilities in rural and urban areas, with particular reference to centres for the management of high risk cases amongst mothers and children, IUD insertion, sterilisation surgery, MTP and the establishment of an organised referral system. These proposals may require to be included in the health plan outlays of the district and the state.

Measures to Improve Logistics and Supply Management

Suitable measures may be undertaken to improve the logistic and supply management within the District with particular reference to the transport, POL, equipment, drugs, vaccines, nutritional supplements, contraceptives, oral rehydration salt, educational materials etc. required by the MCH & FW programmes.

Involvement of Practitioners of Indigenous System of Medicine

Practitioners of indigenous systems of medicine, and other local health practitioners on promotive and preventive maternal and child care and family planning may be invited in seminars to seek their cooperation sought for propagation of ideas and messages and referral of cases.

Information Education & Communication

Opportunities may be utilised through mass media of communication such as radio, T.V., public meetings, articles in the local newspapers etc. to propagate the importance of accepting MCH & FP services; education and economic emancipation of women; and

biological considerations for raising the marriage age of girls.

Inter-personal Contact

Face to face inter-personal talks at individual level may be held particularly with opinion and religious leaders of resistant communities, leaders of labour unions, managers of industries etc.

Public Notices

Public notices may be put up at prominent places indicating to the people of the locality the exact place, day and time of the week etc. at which specific MCH & FP services can be obtained by them.

Holding of Press Conferences

Press Conferences may be held at the inauguration of important facilities and activities related to family welfare. Press to be invited to specially cover MCH & FP activities and agencies and individuals making outstanding contribution to the progress of family welfare in the district.

Local official mass media to communicate consistently themes of social change essential for acceptance of small family norm and regorously screen out all talks, dramas, films etc. which convey messages contrary to the desired social change.

A ten minute health/population education talk may be given immediately after the prayer in all schools. District health and family welfare officials may be requested to develop small family norm messages for these talks.

Anganwadi workers in ICDS blocks and school teachers may be directed to organise and conduct parent meetings to popularise acceptance of MCH and family welfare.

Members of village health committee, wherever constituted, may be requested to divide the village households amongst themselves, depending upon their local influence and go from house to house to inform and motivate people in favour of accepting MCH/family welfare programmes. The official health workers be directed to support the members of the village health committee in this endeavour.

Five to ten minute video casette films of local personalities and MCH/Family Welfare events in local language may be prepared and used in the field and especially in weekly markets/*hats*.

Conferences may be organised of local journalists, Doordarshan and AIR officials to inform them of MCH and family welfare achievements in the district, and to cover important events connected with them.

Sammelans of non-officials attended by State level political leaders may be organised.

Planning of IEC Activities in the District

Pre-requisites for this planning village/town wise are:

- commulative sterilisation rate
- couple protection rates
- Percentage of pregnant mothers receiving antenatal care
- Percentage of deiiveries by trained birth attendants
- Percentage of immunisation of pregnant women with TT and children below 3 years with DPT, Polio and BCG.

These rates are calculated with the help of computers at PHC level and the district statistical staff. The plan of IEC activities is based on these village wise rates which may be found to vary from 5-80 per cent in different villages/towns. These rates should be calculated in April every year and the IEC plan prepared on their basis by holding a series of meetings firstly at the PHC level. In these meetings all strategies for resistant communities are discussed and additional IEC resource requirements estimated in the presence of DEEs and DMEIO.

- At district level all the PHC and Municipal IEC plans are compiled into the district plan which is finalised at the State level in a workshop held to draft the State Master Plan for IEC activities. This workshop is attended by all concerned State/District level functionaries. Central representatives may also attend.
- IEC budget prepared on the basis of this master plan to be sanctioned and conveyed to State and District authorities by the end of April.
- Mass Media Plan at State level to be drawn up in support of the District/PHC plans.
- Educational targets derived from the plan to be calculated PHC wise and worker wise and communicated through D.O. letters directing them to approach family welfare always through MCH. The educational achieves to charging are given below:
- F.W. Exhibition
- 16 M.M. Film show
- Cinema Slides
- Radio Programme
- Local Dramas/Dances
- Harikatha
- Folders
- Posters

- Booklets
- Leaflets
- Calenders
- Wall Slogans
- Banners
- Hoardings/Wall Paints
- Advertisements
- Press Notes
- O.T.C. (MALE) and FEMALE
- Mini O.T.C.
- Village Health Committee Meetings
- Mike Publicity

Community Participation in Family Welfare Programme

Prizes by themselves may prove inadequate. It will be necessary to prepare schemes of incentives for gram *panchayats,* voluntary agencies, local associations etc. in which incentives are linked to the highest achievements of target. The nature of these incentives could vary according to the needs of individual agencies. They could be cash payments or fulfilling priority development needs *e.g.* approach roads, schools etc.

Village Health Guides could be provided higher incentives on per capita basis for bringing sterilisation cases.

Letters of appreciation may be sent to leaders of tribal, minority and resistant groups for family welfare work.

A system of field agents may be organised for family welfare as done by L.I.C. These agents may be given a commission, higher than the incentives currently being paid, to health and development staff for each family planning case. These agents should be drawn from the local communities and no outsiders should be appointed.

Special package schemes may be prepared to tackle resistant communities which include specific educational approaches, appointment of their agents (as in above para), higher incentives to acceptors and higher fees to motivators, and speical dialogue and interviews with their religious/opinion leaders.

Commitment

Commitment is of two kinds:

1. Official or formal commitment, which is easily obtained by the exercise of power and authority. Such a commitment is always short lived and is discarded as soon as the power and authority on which it was founded cease to exist. It

therefore does not have a long lasting impact on the programme.

2. Conscious commitment, which is based upon mature understanding and personal conviction of the importance of the programme. Such a commitment is long lasting and continues to reach for programme goals even in the absence of formal power and authority. It therefore has a long lasting impact and work is done sincerely and honestly.

One of the most important functions is therefore to gauge the level of commitment in the implementing staff. It must never be presumed to be of a high order. If found to be low, the most important roles is to strive to make it high through processes of reasoning, participative functioning and mutual trust and respect.

Every change or introduction of new strategy in the programme requires fresh consent and commitment to be obtained from the implementors. A constant feedback of programme up-dates to staff at all levels, is therefore essential for keeping faith with them. These up-dates may not only provide information on extent of achievement of different targets or introduction of new strategies but may also include items of human interest such as the health of patients who developed post-operative complications following sterilisation and had been referred to District/Sub-divisional Civil Hospital for treatment.

Clarity of goals and plans is another aspect for securing commitment. It requires placing before the implementors a clear time table of work so that there is no confusion regarding who will do what, where, when and how.

Motivation

Motivation entails efforts aimed at making the implementing staff percieve their work as being beyond the narrow call of duty and in the form of a chellenge to which they must give their best. This challenge is in the nature of a distant dream or vision or ideal. When a large number of programme implementors are motivated they will not stop short at targets but go beyond them and their high achievements will more than make up for failure on the part of a few. Each implementor thus becomes "his brother's keeper" and 'espirit de corps' pervades the organisation.

Continual consultation, feebacks and information sharing, and securing direct and indirect participation of all implementing staff in decision making are the very basis of staff motivation.

The above processes will automatically reveal resource constraints and other difficulties being faced by the implementors in the performance of their duties. Genuine efforts made to solve these difficulties partially, if not wholly, are essential for maintaining the motivation.

Treating all implementors down to the village level with dignity and courtesy and never penalising them for not fulfilling targets of family planning is another essential ingredient of motivation.

Always a positive approach needs to be adopted by praising and placing on record good performance. That this is being done needs to become apparent to the workers by ensuring that MCH/FP performance is included in the confidential reports and it is being taken into account for postings, transfers and promotions.

Implementation

Convey the programme goals clearly with reference to their time and place to the implementors. These goals are set by higher authorities but the District Collector and his team of officials would do well to obtain their acceptance from local implementors by explaining to them how and why they are set and what they imply to each one of them individually. This process requires the breaking down of the goals into different activities and tasks which need to be performed area-wise and worker-wise for their achievement. It is important that this entire process should result in the goals emerging intact being wholly accepted.

Prepare a series of action plans indicating in sequence the tasks and activities and events through which the goals are sought to be achieved and the corresponding chain of responsibilities.

The action plans would therefore be of two kinds:

a. Those required to remove gaps in resources *e.g.* timetable for repair of off the road vehicles; actions for making up shortage of doctors especially trained surgeons by obtaining them on deputation from medical colleges, other districts etc; raising of funds etc.
b. Operational plans for delivery of services taking into account leave plans and inservice training of staff. These would include the schedule of sterilisation camps in the district.

Many such plans have to be prepared as there are talukas/tehsils in the district. Each taluk plan has to be in its turn village/town wise taking into account each kind of functionary *e.g.* talati/patwari,

school teachers, gramsewak, anganwadi worker etc. The time during which the goals have to be achieved enable calculation of the target to be given to individual workers.

It is found that when this process is done involving all the possible field functionaries the target per individual becomes low and manageable and this automatically encourages the implementor to think about some suitable local strategy for achieving it.

Keep the plan and strategies flexible and allow implementation techniques to emerge in response to different local conditions and get embodied in the programme as it gets going. There is thus a very thin dividing line between implementation and strategy making and the programme remains responsive to such suggestions from the functionary.

Monitoring of Family Welfare Programme

Equal Attention to MCH & FP

Pay equal attention to the implementation of family planning and maternal and child health components of family welfare programme. Instructions may be issued to District Chief Medical Officer that appraisal of the performance of individual workers and service giving units should be based upon equal importance being given to the achievement of MCH & FP targets.

Periodic Reviews

Periodic review of the programme through meetings, field tours and prescribed reports may be made to ascertain:

- any major problems and deficiencies which require immediate remedial measures
- staff competance and attitudes to motivate and render services
- availability of transport, equipments, and supplies
- immage of the programme in local communities
- any other special problems and grievances in the programme

Review of Deaths

The number of deaths occuring as a result of sterilisation surgery along with assessment of their causes and circumstances to be ascertained periodically from Chief Medical Officer. A constant feedback may be requested from health authorities of the remedial and preventive measures undertaken to prevent such deaths in the future.

Eligible Couple Register

Chief Medical Officers be directed to update eligible couple registers at the close of the financial year. An action plan indicating the dates for completion of registers by field staff, checking of their authenticity by supervisory staff, and random verification by higher officers may be obtained and monitored.

Vital registration authorities in the district to be directed to establish linkages with the eligible couple registration system at village, sub-centres, primary health centre/block/town and city levels.

Data in the updated eligible couple registers needs to be compiled in April to obtain village and town wise the total number of eligible couples with two or more children the number amongst these already sterilised, and the number available for sterilisation.

During intensive camps and campaigns a system of daily postcards from PHCs and urban cetnres may be instituted indicating the number of sterilisations, IUD insertions, immunisations etc.

District's daily/monthly average of sterilisations and IUD insertions may be prepared for every PHC and urban centre.

Overall assessment of qualitative aspects of the programme and its impact on the demographic situation may be made annually from the following information to be obtained from the vital registration and eligible couple registration systems.

- birth rate
- death rate
- infant mortality rate
- average age at marriage of girls and boys
- number and percentage of women having two or more children using contraceptives
- distribution of family planning acceptors of different methods by number of living children.

Vigilance Cases

District vigilance machinery be directed to immediately report any vigilance cases in connection with the maternal and child health and family welfare functionaries in the district. Supervisory attention be given to the speedy disposal of these cases according to prescribed procedures.

Inspections

Surprise personal visits may be made to MCH/FP Service Centres and important activities *e.g.* sterilisation camps to observe the manner in which MCH&FW services are routinely delivered at all levels from village upto civil hospital and in camp situations. Such surprise visits may be coordinated with routine field tours to any part of the district, with on the spot decision being made to visit MCH/FP service centre or camp.

8. Thrust Area for Special Efforts

Towards solutions of problems related to population stabilisation and MCH care, District Collector may take up the following as areas of his immediate and direct concern:

Child Survival and Immunisation

Special drives for intensive immunisation with the help of health, agriculture, tribal and social welfare and other concerned government departments and non-government organisations within the district.

Assistance for the development of publicity material for such drives and deployment of local field publicity units such as local puppet and dance and drama troupes for widespread information and education of the public to accept immunisation of children 0-3 years of age.

Audio-visual documentation of intensive immunisation drives for use by local mass media especially cinemas and report of high and low performance areas to public opinion leaders and elected representatives.

Major problems obstructing efforts to control diarrhoeal diseases within the district require to be solved. These efforts would include the districts' decade programme of water supply and sanitation, housing and slum improvement schemes, procurement and distribution of oral rehydration salts, and public education.

Raising the Status of Women

Employment opportunities within the district for women should be reviewed and strengthened.

Training and educational centres for young girls, linked with specific employments such as creches, anaganwadis, pre-school nurseries, community cooking centres, agro-based production centres etc, may be established.

Block wise action plans for setting up such centres with the help of local mahila mandals, women voluntary agencies, rural banks etc.

Enforcement of directive to ensure 30% women beneficiaries to

be in programmes such as TRYSEM, IRDP and the various Rural Employment Guarantee Schemes etc.

Promotion and adoption of development schemes and technologies to reduce the burden of women *e.g.* bio-gas plants, smokeless chulhas, social-forestry for augmenting local availability of fuel woods, water supply, sanitation, inexpensive pressure cookers etc.

Raising Age at Marriage

Intensive publicity campaigns to create awareness of the legal requirements regarding the age at marriage and health and family welfare purposes served by the Child Marriages Restraint Act 1978.

Bringing to the notice of the State Government any public personality including high level government official guilty of breaking the law regarding age at marriage for appropriate punitive action.

Create 'Social Reform Groups' in different sections of the community such as students, out of school and college youth, community leaders and elders etc. to start a mass movement for education of girls, delaying their marriages and encouraging their participation in social and economic activities. Social and voluntary organisations and field workers of health and family welfare, social welfare and rural development departments, members of popular committees at all levels may be involved to promote this movement.

Organisation of Motivational Campaigns and Service Camps

Owing to the slow pace of development of primary health care MCH/FP infrastructure in rural areas and urban slums, it will be necessary for some time to include camps and campaigns in the strategy of the family welfare programme. Whereas the primary resposibility for organising and conducting these camps will reside with the districts health machinery, the District Collector may take the following actions:

- Direct the Chief Medical Officer to submit the areawise schedule of campaigns and camp within the district so that he may plan to personally visit some of them during his field tours and satisfy himself that the services are provided by adequately trained teams in proper sanitary conditions and that there are satisfactory arrangements for prior physical examination, investigation and follow up care.
- Institute investigation/enquiry of any death and serious complications occuring in camp situations primarily in order to prevent such an occurances in future.

The systematic measures that are adopted by a District Collector for organising mass sterilisation camps, are enlisted in detail in Appendix.

Methods for Fertility Control

The Government of India under its family planning programme makes available a variety of contraceptive to choose from. Several methods of fertility control are being used, and newer methods of contraception are being developed. The contraceptives in use are described below. In the past when few contraceptives were available, coitus interruptus and post-coital douches were used.

These methods are of great importance of newly married couples and those who have not completed their family size.

Spacing Methods

A. *Traditional methods*

- Condom
- Vaginal diaphragm
- Spermicides
  - (a) Jelly, cream and paste
  - (b) Foam tablets
  - (c) Aerosol foam
  - (d) Suppositories
- Rhythm method of safe period

B. *Modern methods*

- Oral contraceptives
- Intrauterine devices

C. *Medical Termination of Pregnancy (MTP)*

Though medical termination of pregnancy results in decreasing the number of births, it is being promoted in India primarily as a health measure. MTP has been legalised to prevent maternal deaths due to illegal abortions performed under unhygienic conditions and by incompetent persons.

Surgical sterilisation

Permanent Method

Advantages and Disadvantages of Various Methods

1. *Coitus interruptus:* In this method the male partner withdraws the phallus before the climax is reached and the ejaculate is deposited outside the vagina. It is probably the oldest contraceptive procedure known to man. It has been used quite extensively in some countries. High degree of motivation and perfect understanding between partners are necessary. The failure rate is quite high.

Advantages

i. It requires no supplies
ii. No specific preparation is needed
iii. It costs nothing

Disadvantages

i. It demands self control of the male.
ii. Women may not get full sexual satisfaction; additional mannual stimulation may be necessary for sexual satisfaction.
iii. It has been reported that tension and neurotic complications may develop in some.
iv. Practice is limited.
v. Pregnancy rates are high.

2. *Post-coital douche:* Post-coital douche with plain water vinegar and various other products have long been used for contraceptive purposes. It is intended to remove the sperm mechanically from the vagina and the chemicals used may have the ability to kill and/or immobilise the sperms.

Advantages

i. It may be useful only as an emergency measure *e.g.* if condom bursts.

Disadvantages

i. It is least effective and pregnancy rate is quite high. After the sex act, the sperms can reach the womb within 90 seconds, thus allowing not much chance to be washed out.
ii. It is inconvenient, and its use has declined and should be discouraged.
iii. Repeated use of strong solutions may cause damage to the vaginal wall.

3. *Prolonged lactation:* For a long time women have known that the likelihood of pregnancy in much less after delivery if they breast-feed their babies. This has led to deliberate extension of lactation with the intention to delay or avoid pregnancy. During this period ovulation is kept suppressed and amenorrhea is prolonged. However, it is recommended that

6 weeks after giving birth to the baby, a woman should use a contraceptive (except oral pills, or any hormonal preparation, which interferes with satisfactory lactation)

Advantages

i. It costs nothing. Prolonged breast-feeding is practised in many developing countries, although extent of its being practised as a contraceptive measure is not known.
ii. No special preparation is required.

Disadvantages

i. It cannot postpone pregnancy indefinitely.
ii. Pregnancy may sometimes occur even before the reappearance of menses after delivery.
iii. Prolonged breast-feeding may lead to malnutrition of the child, if no supplementary food is given.

4. *Condom:* It is made of rubber and it is intended to cover the male organ so as to prevent the sperms getting into the vagina. To reduce the risk of bursting during use, it is important to leave half an inch or more at the end free and empty of air at the time of unrolling it on the erected male organ. Soon after the climax in male partner is over, the male organ gets smaller and the condom becomes loose. It is very important that immediately after the climax the male *organ* should be carefully withdrawn holding the condom securely so as to prevent any leakage from the sides. The effectiveness of this method is increased if used along with some contraceptive — jelly or cream.

Advantages

i. Protection against pregnancy as well as veneral diseases.
ii. One of the most popular methods used widely in all countries.
iii. Easily used in all situations, with no side effects.
iv. Intact condom after use is reassuring to the couple.

Disadvantages

i. Foreplay before sexual act is interrupted.
ii. It may interfere with sex enjoyment in some.
iii. It requires privacy for storage, use, and disposal.

5. *Vaginal diaphragm:* It is made of rubber and has a circular metal rim. It is used by women as a mechanical barrier for the

sperms at the entrace to the cervix. Since it may not fit tightly enough to prevent completely the passage of sperms, it should be used with some chemical sperm-killing agent available in the form of jelly, cream or paste. It comes in different sizes and should be initially fitted by a doctor or a trained para-medical person. Then the women may be taught how to use it. Presently, this method is not being used.

Advantages

i. No side effects are usually noted.

Disadvantages

i. Women need physical examination and it should be initially fitted by a doctor or a trained health personnel.
ii. Privacy is required for fitting.
iii. Its effectiveness varies in different populations; it is not suitable for poorly motivated people.

6. *Spermicides:* These chemical agents are administered intera-vaginally as jellies, creams, foam tablets or suppositories with the object of killing and/or immobilizing the sperms. Since these are relatively less effective, other mechanical devices such as diaphragm or condom should accompany their use. These are introduced into the vagina 10 to 15 minutes prior to sexual intercourse.

Advantages

i. Relatively simple to use; the foam tablets are more effective than others.
ii. Pelvic examination is not needed.

Disadvantages

i. Cause excessive lubrication and 'messiness'.
ii. Some waiting time is required.

7. *Rhythm method or safe period:* This is based on avoiding sex act during the possible fertile period of the menstrual cycle. The release of the egg usually occurs about 12 to 14 days prior to the onset of next menses, and the egg remains alive for less than 24 hours. The sperms, once deposited into the vagina, may remain alive in the female genital tract for about 2 to 4 days. Taking these facts into consideration calculation of safe period is made in each woman. In a regular menstrual cycle of

normal length, usually 7 or 8 days prior to the expected date of menses and 3 or 4 days just after the stoppage of menses may be considered as safe period. However, this method alone has a very high failure rate; therefore, this should be practiced in combination with other methods such as condom.

Advantages

i. Only method accepted by Roman Catholics.
ii. No side effects.

Disadvantages

i. Opportunity for sex act is reduced.
ii. Not suited for women with irregular menses and for uneducated people.

8. *Oral contraceptives:* Commonly used oral pills are various combinations of two types of female sex hormones *i.e.* estrogen and progestogen. The pills are to be taken from day 5 to 25 of each cycle, or in courses of 4 weeks duration the last week of this regimen having non-hormonal tablets. Withdrawal bleeding occurs 3 to 4 days after the intake of the last pill in 21 day course, and during the last week in the 28 day schedule. These oral pills act at multiple sites and suppress ovulation, interferes with sperm passage through cervical mucus and make the endometrium unsuitable for embeding of fertilized egg. The pills have to be taken everyday, whether or not sexual contact is made.

Advantages

i. If properly taken, almost cent percent effective.
ii. Use is not related to sex act.

Disadvantages

i. Requires counting days of menstrual cycle.
ii. Remember to take the pill everyday.
iii. Mild side effects may occur and many women may discontinue for this reason, if they are not properly counselled and reassured.

9. *Intra-uterine contraceptive devices:* Various plastic devices (IUDs) have been extensively used in the human, and pregnancy rate is very low. The device is introduced into the uterus by a doctor or a trained nurse and a periodical followup is done.

In more than 50 percent of women there is no complaint whatsoever. Those who cannot use the device some alternative contraceptive should be used; oral pills may be given to such elients. IUD prevents implanation of the fertilized egg into the endometrium. Sometimes the IUD is spontaneously expelled under such circumstances, contraceptive protection must be sought immediately.

Advantages

i. Suitable for large scale programmes.
ii. Needs one time decision and action.
iii. Economical.
iv. Pregnancy rate is low.

Disadvantages

i. Side effects such as bleeding, pain etc. are varied, and may be mild and transient in many.
ii. Many may discontinue for side effects, unless properly educated, counselled and reassured.

10. *Surgical sterilization:* In vasectomy and tubectomy the continuity of the ducts meant for the transport of spermatozoa and egg respectively is interrupted. These operations are carried out in those couples who need family limitation. Although these methods are considered as permanent methods, these operations can be reversed successfully in a proportion of cases. Using microsurgical techniques success rates have increased considerably. Attempts for development of completely reversible methods for vasocclusion and tubal occlusion have not been successful.

Advantages

i. These give maximum protection and side effects are minimum.
ii. These need no further action.

Disadvantages

i. The operation may not be reversed successfully in some cases, if and when needed.
ii. Emotional reactions may occur in a few cases.

Medical Termination of Pregnancy

The regulations about pregnancy termination have been liberalized recently in many countries. In India, it is now possible to terminate unwanted pregnancy likely to adversely affect the physical and psychological well being of the mother. Failure of contraceptives is one of the indications for Medical Termination of Pregnancy (MTP). This should not, however, be resorted to as a matter of routine. The earlier the help is sought, the easier is the procedure and the lesser is the rate of complications. This should be carried out in approved centres or hospitals. People should be properly educated about these aspects.

In India, MTP has been permitted on the ground of maternal health, because illegal abortions carried out by unskilled persons at unauthorized places are very risky, and maternal deaths and morbidity are very high. Strictly speaking, MTP is not considered as a contraceptive in this country. Nevertheless, undoubtedly it prevents child birth. Furthermore, the very fact that they come forward for induced abortion shows that they are highly motivated against having unwanted pregnancies. Therefore, they should be responsive to counselling for accepting small family norm.

Relative Effectiveness

The effectiveness of various contraceptive methods is expressed as the number of pregnancies occurring in 100 women using the method for one year period. The relative effectiveness of various methods is given in Table 1.

Table 1. Effectiveness of Contraceptive Methods

Method	Average Pregnancy Rate per 100 Women Use for One year
Douche	37.8
Foam tablets	22.0
Jelly alone	20.0
Coitus interruptus or withdrawal	16.0
Safe period	14.4
Diaphragm	12.0
Condom	11.9
Intra-uterine device (Lippes loop)	5.0
Copper IUD	1.0 or less
Oral pills	0.80

Recent Advances

Although several effective methods are currently available and efforts are being made for maximum utilization of the available effective methods, vigorous attempts are being made for improving the existing methods and also for finding leads for new techniques of fertility limitation. Two of the new approaches, which are at

various stages of clinical trial and hold good promise are highlighted below:

1. *Sub-dermal implants of progestogens:* Sub dermal implants are silastic tubes or rods containing different progestogens have been shown to cause slow release of the steroid and to have contraceptive effects which may last for 5 to 7 years. Several progestogens have been tested so far, and very encouraging results have been obtained with levonorgestral, being used in 'Norplant/Norplant II.'

Advantages

a. One time administration provides protection for a long period, and therefore day to day vigilance is not necessary.

Disadvantages

a. Irregularity of menstruation is the most frequent side effect, but the total blood loss is not more than what occurs during normal menstrual bleeding.
b. The method requires insertion and removal under sterile conditions. Use of biodegradable material in Norplant II may obviate this difficulty to a great extent.

2. *Anti-pregnancy vaccine:* Considerable progress has been made in the development of an anti-HCG vaccine by a group of scientists in Delhi and by another group in the U.S.A. The aim is to develop sufficiently high titre of anti-HCG antibody by active immunization so that it could interfere with the naturally occurring HCG before a nascent pregnancy becomes established. As has been mentioned earlier, for the maintenance of conceptus immediately after implantation, continued supply of estrogen and progesterone from the corpus luteum is essential. This corpus luteum function in early pregnancy is maintained by HCG. Therefore, neutralization of the action of HCG by anti-HCG antibody prevents pregnancy. This would be an important breakthrough in contraceptive technology, if its efficacy and reversibility could be established and any major side effect could be avoided.

Suggested Steps in Organising Sterilisation Camps Including Laparoscopic Camps

The District Collector has a key role in getting the day to day family welfare, MCH care and related programmes in the district effectively organised at all levels.

Organisation of the Camp

Some important elements for the successful organisation of sterilisation camps in the district are:

Advance planning

- Updating the target couple register before camps; involvement of formal and informal leaders; FW & MCH performance of the district in the past; technical facilities available; peripheral staff in position; communication facilities; other local factors likely to bring success to the camp.
- Efficient organisation and management
- Information, education and motivation
- Defining roles of officials
- Mass publicity
- Quality of services and follow up
- An appeal needs to be made by the District Collector requesting for support of individuals and organisations.
- Nomination of Officer incharge of the camp
- Administrative and technical planning

Division of work and responsibilities;
Publicity and field work;
Place for operation;
Logistics and supply;
Staff deployment;
Incentives and additional inputs;
Followup etc.

Some detail out of the District Collector with reference to broad steps in organising sterilisation of camps are as follows:

Advance planning

Of all the elements, advance planning, is the most important for effective and successful organisation of sterilisation camps. The guidelines of the Department of Family Welfare, Government of India, for organising large vasectomy camps suggest that the following points should be taken into account before organising camps.

Updating target couple register: The District Collector may ensure through District Family Planning Officer that the target couple registers are updated as a part of initiating advance planning for the camps.

Performance of District in the past: It is necessary to identify blocks/or areas of district, where performance in family planning over the years has been very low; a different strategy needs to be used for these areas. District Collector may obtain this performance statistics from/through the District Family Welfare Office or his own control room in the collectorate.

Available technical facilities

It is necessary to take to know stock of available facilities, particularly those required for technical services like arrangements, for operation, trained doctor surgeons etc. is a must part of advance planning for organising mass camps.

Peripheral staff in position

Unless the supporting medical and para medical staff is adequately available to cater the services before, during and after organising the sterilisation camps this may bring those very problems and deficiencies which have been cited in the past wherever such camps were not successful. So, it is necessary to ensure the availability of staff before the organising camps. It may be necessary to issue instructions to ensure that they are present during the period required.

Communication facilities

This factor is related with the location and selection of camps site. As far as possible, the camp should be in such a place so as not to cause much of communication/transportation difficulty etc. to the prospective acceptors. The place so chosen should have good communication facilities in terms of accessibility by people and the functionaires both.

Other local factors

The cognisance of such local situations and local factors may be taken as a part of advance planning which may cause hinderance in the success of the large mass sterilisation camps viz. the date of organising such special family welfare event should not coincide with any other big fair, festival or event in the area etc. because organisation of sterilisation camps require additional inputs which have to be sometime borrowed/requisitioned from neighbouring district or requested from state. As such it has to be seen that large vasectomy camps are not being organised simultaneously in neighbouring district/areas.

Efficient Organisation and Management

Beside a detailed advance planning, organisation and management are also important for achieving success of the sterilisation camps in the district. The activities involved in organisation, management and follow up require an 'institutional expertise' to be created and which has to be functional. This 'institutional expertise' has to be not only technical in terms of medical or surgical requirement but also a conscious input and induction of management professionals, and cooperation of inter-departmental nature is required. Here, District Collector being District Coordinator-in-Chief can play an effective role.

In general, all the staff of the District Family Welfare Bureau of the district where the actual camps are to be held may be involved. In addition, District Collector in consultation with District Family Planning Officer may borrow or request the state authorities for requisition of the services of surgeon-doctors, para-medical and other staff from neighbouring districts where camps are not held at that time. The District Collector may instruct the associated institutions, blocks and Panchayats to extend full cooperation in terms of manpower, vehicles etc. for organising the sterilisation camps.

Appeal by the District Collector

An appeal by the District Collector has to be made just after he has taken the stock of the situation and advance measures for planning the camp are done. The appeal may be worded nicely, and needs to be approppiately comprehensive. In general it may highlight the importance of family welfare and MCH programme as part of overall welfare measures alongwith objectives of the sterilisation camps to be organised. The appeal can go as a press-release, as well as in the form of personal letters and request eliciting the cooperation from all concerned. In particular it may be in the form of demi-personal letters to:

i. MP/MLA/MLC of the area

ii. Public leaders and Panchayat presidents
iii. Divisional/District level officers of other departments in the district.
iv. Block Development Officer.
v. Government and Private undertakings in the area.
vi. Heads of the teaching institutions
vii. Private medical practitioners
viii. Voluntary organisation and their functionaries.
ix. Charitable institutions and social organisations like Rotary clubs/Lions clubs etc.
x. Prominent and influential persons in the district at all levels.
xi. Media institutions at all levels in the district.
xii. Evaluation cells and bodies in the district.

Officer In-Charge for the Camps

The guidelines issued by the department of family welfare require that two functionaries, one technical officer/and other camp officer, may be given the technical and administrative charge of these camps under the guidance of District Collector, alongwith committee formed at various levels for division of responsbilities at these levels.

Technical Officer: Professor and Head or Associate Professor of Surgery of a Medical College/qualified surgeon incharge for overall supervision and guidance of the technical arrangement and surgical work.

Camp Officer: Chief Medical Officer/District Health Officer District Family Planning Officer of the district for organisation and management of administrative aspects of the camp.

Deployment of other staff: In addition to the technical and administrative incharge, the staff of the District Family Planning Bureau and the staff of family welfare department.

Committees are to be overall responsible for promoting targetted number of couples for the sterilisation camps from their corresponding areas. Each committee may further form sub committees for different activities such as publicity, transport, camp arrangement, service, food remuneration, after care, complaints-solving etc.

Division of Work and Responsibilities

A circular issued by the District Collector should defineate the responsibilities of each functionary to be involved in organising and in managing various aspects of sterilisation camps: each one should get a detailed guideline about activities to be taken up for which

District Collector may be prepared with the help of the DFPO. These circulars will be instrumental in ensuring that non-official workers as well as official functionaries from department of family welfare and other departments work as a single cohesive team.

Scheduling of Areas for Participation

A schedule indicating where the camps are to be held must be prepared and distributed. At one time, camps should organised in 2-3 blocks or panchayats or municipal areas, to ensure proper management.

Education, Motivation, Publicity and Field Work

To the people, sterilisation camps should act as a 'catalytic agent' in developing a frame of mind for accepting the terminal methods. The prospective acceptor should not think that he or she is the only person going for sterilisation. Special and comprehensive motivational campaign need to be organised. Satisfied acceptors are effective motivators, as they can cite their own example.

Besides, organising and motivating battery of people and groups through interpersonal contacts District Collectors may see that extensive publicity and rigourous field work has been organised by District Collectors in support of the camp. Public meetings have to be conducted in every local area, viz. Panchayats and also in Municipal Wards etc.

This intensive field publicity and educational efforts are to be started quite in advance say a month and so before organising the sterilisation camps. Either the District Collector or his associates may have to attend the publicity meetings in the district at all levels to get the broad based support for the programme. Also regular press releases have to be issued and the appeals have to be broadcast over the radio. For the publicity work in the villages; street/corner meetings, posters, banners and local theatres and other activities of educational, communication and information would have to be developed and organised.

The District Extension and Mass Media Officer, District Information Officer, Officials of press information breau and other news agencies, District Agriculture Extension Workers, etc. will be utilised by the District Collector before and during the camps.

The number of persons registered has to be got critically reviewed by District Collector in the light of reports received through his associates. Leaders of the village community, local medical practitioners, womens' organisations, prominant village leaders should not be missed. The entire district and its various blocks/pockets/need to be

covered through intensive field work and publicity prior, to organising the camp.

Special motivation through intensive and concentrated field work has to be done in those identified and selected pockets where the profile of programme has been low in the past.

Camp Arrangement, Quality of Services and Follow up etc.

Department of Family Welfare, Government of India has brought out detailed guidelines for organising large scale vasectomy camps. These guidelines have been sent to all state and district officials. For technical aspects, District Collector may ensure, through DFPO, that these guidelines are received by all the concerned officials at all levels and also followed by them while organising sterilisation camps. An abridged version of these guidelines is reproduced in the following paragraph for a ready reference of District Collector and for a technical monitoring the programme.

Control Room

District Collector should see that he operates through a control room, which is organised in his office and presided over by his seniormost colleague or District Family Planning Officer. This control room would be instructed by District Collector to maintain liaison with other control rooms maintained at the site where camp/camps are being organised. Through these control rooms District Collectors may supervise and coordinate the activities of the sterilisation camp. He can use his direct and continuous contact with control points to take immediate and corrective actions when situation requires it. Besides his senior most collegue and DFPO, a skeleton staff may deputed to function in the control room for effective functioning of the camp.

Mobilisation of Resrouces

District Collector has to mobilise various resources for the successful organisation and management of sterilisation camps in the district. Here, his real authority, role/capacities for intersectoral cooperation and collaboration are required for effective impletation of special events of social change like camps. District Collector by virtue of his authority can mobilise the resources in terms of the personnel viz. Block Development Officer, Block Extension Officer, Village Extension Officers and health and family welfare personnel working at various levels in the block, particularly for the camp period.

Incentives

Although some nominal incentives to promotors and acceptors of terminal method are given by the Government, yet District Collector can mobilise additional resources for giving higher incentives to the acceptors as well as promotors during the campaign period. District

Collector may also encourage the workers by announcing suitable awards/incentives to the workers, engaged in the camp. These incentive can be in many forms including money. Incentives can be given by District Collector not only to officials and non-officials but also to the organisations and departments like panchayats etc. for bringing the cases for sterilisation.

Quality Maintenance

District Collector may see that quality is maintained uniformly. This quality conciousness may start right from the registration, screening and selection of cases with medical check-ups and rejecting the non-eligibles. Pre-operative preparation, pre-operative education, pre-medication operation theatre arrangement, following of procedures and techniques of operation, post operation treatment, post operative instruments, follow up and its procedure — all these stages/points/aspects/activities contribute towards the quality control. District Collector has to see administrative, organisational and technical programme aspects in getting organised sterilisation camps with the help of DFPO and other staff at various levels in the district.

Followup Procedure and Arrangements

The success of organising sterilisation camps, whether vasectomy or laparoscopy, will not be complete unless the cases operated are not followed up once or more than once. The first follow up should be immediate, and the second follow up will be later, where District Collector can get systematic folllow up services organised. Follow up literature may be printed, giving general and detailed instructions to the acceptors and motivators. Secondly, District Collectors have an important role in follow up in which departmental officials as well as non-official functionaries organisations, agencies who were inducted to participate in the camps should be involved. Whenever and wherever complications are found by District Collectors, instructions will immediately be there for corrective measures and refer the cases to Primary Health Centres and District Hospitals. He can constitute follow up committees and follow-up teams, including in all these teams, medical as well as communication functionaries.

Information on complaints attributed by acceptors and others to these camps may have to be collected under the instructions of District Collector. The information on complaints through follow up studies by District Health Statisticians and others, will give a complete idea about how future camps should be held. This information should be useful for organising medical services for attending physical troubles and other psychological complaints which may have to be dealt through a communication back up. Mobile units can also be made use of to supplement the facilities of the primary health centres for the follow up purposes.

Organising of Sterilisation Camps for Laparoscopic

The laparoscopic method of tubal occlusion has gained considerable popularity during the last few years. This is a technique of female sterilisation through abdominal approach with a specialised instrument called 'Laparoscope'. The operation, however, can only be performed by a trained team led by a Gynaecologist/Surgeon. The short operating time, shorter stay in hospital and a small scare are some of the attractive features of the operation. In order to maintain its popularity, utmost importance will have to be attached to the qualitative aspects of the programme. Proper training of the teams, adequate arrangement for facilities of sterilisation, proper selection of cases and followup of the operated cases have to be ensured.

a. Maximum number of cases per team in camp should be 30.
b. Two sets of Laparoscopic and minilap instruments per operator/surgeon should be used to shorten the waiting period.
c. Maximum number of cases to be operated per day at a fully equipped PHC should be 30. This number for an upgraded PHC or for a Taluka level hospital or other institutions should not exceed 100.
d. Two operating tables should be available for use.

Laparoscopic Camp: Only persons with postgraduate experience in Obst. and Gynae. of at least 3 years and having done more than 500 laparoscopics are considered competent for operation.

Minilap camp: Any qualified gynaecologist or surgeon with three years' experience can organise a minilap camp.

Sterilisation: Laparoscopic equipment is to be sterilised by Formalin vapour/Cydex solution. The ancillary instrument may be kept for any length of time but the optic should be kept only 10-15 minutes in Formalin vapour or Cydex solution.

Avoid cleaning with spirit alone.

Gases: Gas is reauired for creating pheumo-paritoneum for

laparoscopy. Following is the preference list in descending order:

a. CO_2
b. Nitrous oxide
c. Air.

Hospital Stay: Patients are recommended hospital stay for a minimum of 48 hours. However, if the patient is unwilling, she can be permitted to leave after 4-6 hours. provided the pules, temperature and B.P. are normal, and the surgeon is satisfied and willing to undertake the responsibility for such early discharge.

Follow-up Care: Follow-up after sterilisation procedure is essential. The two periods (short-term and long-term) recommended are:

a. 7-10 days
b. 12-18 months.

Site: A suitable site should be selected keeping in mind electricity, running water, vanitaliation and sterilisation facilities. At peripheral level the method of choice of PHC is a Minilap Sterilisation. But at a teaching institution, where expertise is available, it may be Minilap and/or Laparoscopy.

Training in Lapraocopic Tubal Occlusion

It is suggested that District try to have a minimum of two trained teams per one laparoscope. This would ensure optimum utilisation of the equipment. States/UTs wanting to avail of the training facilities in any of the nine central institutes may kindly intimate Deputy Commisioner (Technical Operation), Nirman Bhavan, New Delhi, who will make necessary arrangements for the training of the team. The constitution of the team has already been detailed above.

Laparoscopic Technique

During the recent years, there has been a distinct trend towards female sterilisations; currently approximately 80 per cent of all sterilisations are female sterilisations. Laparoscopic sterilisation, which is a technique of female starilisation through abdominal approach with a specialised instrument called laparoscope, has become extremely popular. The operations is performed by a trained team led by a surgeon/gynaecologist. The attractive features of the techniques are a small scar, short stay in hospital and a short operating time. At present, there is a great deal of unsatisfied demand in most parts of the country for sterilisation by this technique. Continued popularity and greater acceptance of this programme have to be ensured, For this purpose, it is important that:

i. Laparoscopic operations are performed by duly trained teams;
ii. Services are available under proper sanitary conditions and on regular basis;
iii. Prospective acceptors are throughly examined prior to tubal occlusion;
iv. Proper follow up of operated cases is ensured.

Procurement of Laparoscopes

The Ministry of Health and Family Welfare have not provided funds for purchase of this equipment. However, laparoscopes received as assistance from external agencies have been distributed among States/UTs. based on existing demand and availability of trained teams in particular State/UT. While the Centre will make efforts to supply laparoscopes to States when available, the State Government of respective districts should continue to purchase the instruments out of their own resources. Miscellaneous purpose fund provided in the amount of compensation for sterilisation cases could also be used for purchase of laparoscopes.

Follow-up Care

The cases are required to be followed by MPWs (Femals)/LHVs in their respective areas once between the seventh and tenth day after the operation, and once again between the 12th and 18th month after operation. Any slackness in post-operative care will damage the programme. It is suggested that Directors/Additional Directors of Health Services should periodically review the post-operative care being rendered and remove difiencies, if any. District Colector should see that the District Medical Officers personally monitor the post-operative care. State level officers during their tour should also review the post-operative care programme of which District Collector should have knowledge.

Guidelines for Female Sterilisation by Laparoscopic Technique

a. The persons working should have adequate experience and training.

b. No one should head a laparoscopy sterilisation team or offer training unless he/she performed 500 laparoscopic procedures.

Period of Training

For laparoscopy techniques, the period should be either 2 weeks or 25 cases, whichever is later. For training, a team approach should be used and the team as a whole should be trained. The team should consists of a doctor (Postgraduate of three years standing), Operation Theatre Nurse and Operation Theatre Technician.

Patient Selection

Proper selection of patients is very important for minimizing the side affects:

a. Laparoscopic sterilization is not advisable for post-partum patients for 6 weeks following delivery.
b. However, laparoscopic sterilisation can be done as a concurrent procedure to MTP.
c. Haemoglobin percentage should not be less than 8 gms percent.
d. There should be no associated medical disease *e.g.* Heart Disease, Respiratory Disease, High Blood Pressure, Diabetes, etc.

Organisation of Family Welfare Leader's Camps

The Government of India is committed to promote the family planning programme on a voluntary basis. The programme is to succeed by becoming a people's movement in which all sections of the society participate.

To convert the family welfare programme into a people's movement, the cooperation of local leaders in every town and village in the country is to be enlisted. These local leaders wield a lot of influence in their communities and are familiar with the local idiom and communication channels. They can be successful, more than outsiders, in persuading the people to accept the small family norm.

An effective nucleus should, therefore, be developed within the communities for diffusion and dissemination of information about the need and importance of the family welfare programme and for the removal of misgivings, wrong notions and prejudices from the minds of the people. This is possible by actively involving the community leaders who have considered influence in the communities they live in. This should be done by organising family welfare leader's camps.

These camps should be conducted in a manner so that there is ample opportunity for free and frank discussion between opinion leaders themselves and the family welfare workers on various aspects of the family planning programme.

General Objectives

These leaders should become, through regular follow-up efforts, centres of support for the family welfare programme.

Selection of Participants

The number of participants in one camp should be between 30 and 40. They should include formal and informal leaders. A formal leader is one who holds an official position in a village, like the Pradhan/Sarpanch, the members of the Panchayat, the office bearers of cooperative society, the school teacher, the postman, the dai, the barber and the priest.

In the village power structure, informal leaders often wield greater influence than officials. For the purpose of family welfare leaders'

camps, we are concerned with only those opinion leaders who are interested in family planning or those who have the potential of becoming active promoters of the programme.

i) Both formal and informal leaders having potential of becoming active promoters of family welfare programme should be persuaded to attend the orientation camps.
ii) It will be advantageous to have persons from various walks of life like political leaders, professionals, farmers, youth leaders, social workers and representatives of religious groups to participate in the camps.
iii) Efforts may be made to enlist adequate number of women leaders so that, after the completion of camp, they may function as opinion communicators among the women folk.
iv) Some camps may be organised exclusively for women leaders so that problems related to women may be dicussed freely without any reservation.
v) Adequate representation should be given to leaders from the minority communities and backward sections of the society.
vi) From each village at least four participants should be selected so that later they may be helpful in the formation of a group to promote family welfare in the village.
vii) Efforts should be made to identify leaders among satisfied acceptors of contraceptive methods who are willing to talk to others.
viii) Panchayat Pradhans, School Teachers, Community Health Guides, Members of Cooperative Societies, Post Masters, Field Workers, Panchayat Secretaries, the village Priest, Village barber, Village dai, retired Government officials, exservicemen and members of village mahila mandals, youth clubs and sports clubs are some of the examples of opinion leaders whose participation in these camps will be beneficial.
ix) Health and Family Welfare Workers, field staff of development departments and the functionaries of voluntary organisations working in the area may be requested to attend these camps as associates or co-organisers.
x) To ensure that around 30-40 opinion leaders participate in the camp, at least 60 persons may be selected.

Arrangements for the Camp

Arrangements for holding the camps have to be made well in advance. It will be better if the proposal for holding the camp is discussed in one of the meetings of the District/Block Development

Committee. Besides health and family welfare workers, field functionaries of development departments/agencies, both governmental and non-governmental, operating in the area should also be associated in the organisation of these camps.

Suitable publicity and motivational material of family welfare should be procured for distribution amongst the camp participants.

The primary responsibility for holding the camp will be assigned to the Medical Officer-in-Charge of the Primary Health Centre and the Block Extension Educator concerned. The District Family Welfare Officer, the District Extension and Media Officer or the District MEMO should supervise the camps.

The list of participants should be carefully drawn and they should be informed in advance, preferably by written invitation, about the venue, date, time and the purpose of the camp. Subject specialists for discussion with the participants and for answering their queries, should be selected well in advance and they may be asked to make advance preparation for the purpose. Discussion plans may be supplied to the speakers well in time. Advance planning will specifically be required on the following aspects:

i) Selection of venue and date of the camp.
ii) Securing cooperation of all the developmental agencies for conducting the camps smoothly.
iii) Finalisation of the list of participants.
iv) Finalisation of the list of those who will lead discussions with the participants on different subjects and contacting them for their consent in advance and to do necessary briefing.
v) Finalisation of the time schedule of the camp after making necessary adaptations as per local requirements in the time schedule.
vi) Preparation of talking points on various topics for the guidance of guest speakers.
vii) Procurement of suitable motivational and publicity materials for distribution to the participants. These should be prepared in the local language. The materials sent from the Central and the State Government should be supplemented at the District level.
viii) Deciding about the appropriate training/educative films to be shown to the participants and making necessary arrangements for their screening.
ix) Making adequate arrangements for food, refreshments,

safe drinking water etc. for the participants and others involved in the organisation of the camps.

x) Preparing the scheme of display relating to various aspects of family welfare programme and making adequate arrangements for the visuals/exhibits.

xi) Assigning and entrusting specific tasks to various field workers in respect of the organisation of the camps.

The forms for the certificates of participation to be awarded to opinion leaders at the close of the camps should be printed at the State level and supplied to districts in adequate numbers. It should be attractive and printed on good quality paper.

The participants should be told as to what is expected of them when they return from the camps. The organisation should assign field workers the responsibility of keeping contact with the opinion leaders for continuing interest in the Family Planning Programme.

Conducting the Camps

The subject matter should consist of applied and functional information having relevance to local needs. During the course of talks and discussion, as far as possible, the examples and illustrations related to the local situations should be given. The talks and discussion may be made more informative and interesting by showing films, charts, etc.

These Camps are non-formal in nature. It must not take the shape of a classroom.

Evaluation

Each Camp should be evaluated by the District Family Welfare Officer/District Extension and Media Officer and a report thereon should be sent to the State Family Welfare Bureau and to the concerned PHC.

Follow-up of the Camps

Effectiveness and the utility of these camps depends on systematic and regular follow-up and liasion with the participants.

For effective follow-up action, it has been suggested that the registers of all those who participate in the camps are maintained at Primary Health Centres alongwith necessary details.

The Block Extension Educator and other field workers should maintain list of leaders trained in the camps and immediately should establish contact with the opinion leaders in their respective villages. Efforts should continue to maintain contacts with them.

Literature on important aspects of the family welfare programme should be sent to the opinion leaders from time to time.

District Level Camps

The interest of the opinion leaders can be sustained by giving recognition for their good work. Further, there is need to generate healthy spirit of competition among them for doing commendable work in support of family planning in their respective areas. This should be done by organising opinion leaders' camps at district and State levels.

The district level camps may be organised at the rate of one camp per district per year. Two opinion leaders who participated in the previous years camps and did commendable work should be selected from every PHC area to participate in the district level camp. In these camps, the participants should be encouraged to exchange their experiences.

Other Points

- The programme of organising Family Welfare Leaders' Camps should be staggered throughout the years.
- Maximum number of camps should be organised before or during National Family Welfare Campaigns.
- The Family Welfare Leaders' Camps may be followed by organisation of mini-service camps, where Family Planning and MCH services should be provided to the maximum number of people.
- Efforts should be made to get the coverage of these camps done by local stations of All India Radio and TV and the local newspapers.
- Wherever desirable local folk media performances should be arranged.
- The actual timings of the camps should be kept as per the convenience of the participants. Efforts should be made to keep the participants busy and sustain their interest in the camp.
- If convenient, Ministers and other distinguished leaders may be invited to the camps. They may be requested to inaugurate the camps at some places and also to address the participants on the need and importance of family welfare.
- Field workers and local officials should have prior consultations with prospective opinion leaders to ensure their effective participation in the camps.

Reporting

A register containing the following information about the camps should be maintained at the PHC:

i) Dates and venues of the camps.
ii) Names of participants, with postal address, their ages, qualifications, marital status, number of children and family planning practice status (if relevant).
iii) Details of expenditure incurred in organising the camp.
iv) Other relevant information.

The register so maintained will also help in compiling reports to be submitted to the higher authorities from time to time and in planning follow-up action for the future.

A detailed report of each family welfare leaders' camp should be prepared at the PHC level.

The reports received from the PHCs should be compiled in Proforma at the District Headquarters and sent to the State Family Welfare Bureau every month and not later than 5th of the following month.

The reports received from the districts will be consolidated and compiled by State Family Welfare Bureau in Proforma C for onward transmission to the Department of Family Welfare, Government of India.

Efforts are to be made to prepare the reports in brief and to the point. Information to be given in the various columns of the proforma should be very specific, objective, and self-explanatory.

Background Information for Planning, Coordination and Implementation of Family Welfare, MCH Programmes at District Level

	India	*Your State**	*Your District**
Population (1981)	685 million		
Decennial growth rate (1971-81)	25.0		
Birth rate (1983)	33.6		
Death rate (1983)	11.9		
Birth rate (1983-rural)	35.3		
Death rate (1983-rural)	13.9		
Infant mortality rate (1982)	105		
Maternal mortality rate			
Expectation of life at birth (1980)			
Male	54.1		
Female	54.7		
Both sexes	54.4		
Sex ratios (females per 1000 population – 1981)	933		
Age distribution (1981) 0–14	39.6%		
15–59	53.9%		
60+	6.5%		
Number of eligible couples in the age group 15.44 years	93143847		
Mean Age at marriage			
Male	22.60		
Female	17.75		
Religionwise distribution of population (1971 census)			
Hindu	82.7		
Muslim	11.02		
Christian	2.6		

	India	*Your State**	*Your District**
Sikhs	1.9		
Others	1.6		
Tribal population percentage to total population (1981)	7.76		
Schedule Caste Population (1981)	15.75		
Literacy rate (1981)			
Total	36.23		
Male	46.89		
Female	24.82		
Rural	29.65		
Urban	57.40		
Percentage Student in Primary Education (6 to 11 years) 1983	87.2		
Work Participation Rate			
Total	33.45		
Male	51.62		
Female	13.99		
Rural	37.76		
Urban	29.23		
Percentage of people below poverty line (1978)			
Rural	50.82		
Urban	38.19		
Total	48.13		
Number of villages connected by all weather road (1982)	165166		
Number of villages electrified (1983)	303036		

Medical Infrastructure Information

Number of Hospital and Beds (1985)

(i) Government	4027/375547	
(ii) Private	3342/139442	
(iii) Total	7369/514989	
Area served by Hospital (Sq. Km.) (1985)	446109	
Population Served by Hospital, (1985)	100177	

	India	*Your State**	*Your District**
Hospital beds per 1000 population	0.70		
Number of PHCs	7250		
Number of Sub-Centres	83008		
Number of upgraded PHCs	613		
Number of Doctors	297228		
Number of Nurses	164421		
Number of medical colleges (1985)	106		
Number of Nursing Schools (1985)	411		
Number of para-medical Manpower in Rural Area			
Health Worker (M)	75396		
Pharmacist	20457		
Lab. Technicians	6972		
Block Extension Educator	4845		
Health Supervisor	24367		

N.B.:

Background information for planning and implementation of Family Welfare, MCH programme etc. can be obtained for respective State/District etc. from the publication of State Family Planning Bureau/District Family Planning Bureau and State/District Statistical machinery etc. Information for the state and India can also be made use from the following publicaiton:

1. Health Statistics of India, Central Bureau of Health Intelligence, DGHS, Ministry of Health & F.W. Government of India, New Delhi.
2. Family Welfare programme in India—Year Book Government of India, Ministry of Health & Family Welfare, Deptt. of Family Welfare, New Delhi.
3. Statistical Abstract of India, Central Statistical Organisations Deptt. Statistics, Government of India, New Delhi.